STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING _____ B. WING _____	R 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	**1345 N MADISON AVE ANDERSON, IN 46011**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/23/13.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00141184 completed on 12/23/13.

Survey Date: 1/30/14

Facility Number: 000005
Provider Number: 155005
AIM Number: 100270840

Survey Team
Tina Smith-Staats, RN, TC
Karen Lewis, RN
Ginger McNamee, RN
Toni Maley, BSW

Census
SNF: 34
SNF/NF 119:
Total: 153

Census Payor Type
Medicare: 26
Medicaid: 97
Other: 30
Total: 153

Manorcare Health Services was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE